	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) [redacted] -MANAGER OF BROMFORD LANE NURSING HOME**
1	**CORONER** I am Mr Adam Hodson, Assistant Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 29 March 2021 I commenced an investigation into the death of Peter Michael HARTE. The investigation concluded at the end of the inquest. The conclusion of the inquest was Natural Causes. The deceased was admitted into Birmingham Heartlands Hospital at 01:27 on 19/03/2021 and was diagnosed and treated for sepsis. His prognosis was poor due to his pre-existing comorbidities and it was determined that a ward-based ceiling of care was appropriate and would preserve his dignity. Sadly, his condition deteriorated despite treatment, and he died with his family at his bedside at 10:25 on 19/03/2021. Prior to admission, he was being cared for in a care home but he was difficult to manage and was non-compliant with care due to symptoms of suspected vascular dementia. During that time, his skin was monitored, but records were not kept between 14th to 18th March. Post-mortem examination revealed pressure ulcers to his buttocks and sacral area, but these occurred peri-mortem and did not cause or contribute to death. His death was due to multiple organ failure and sepsis, stemming from a bacterial skin infection causing cellulitis which sadly did not respond to treatment.
4	**CIRCUMSTANCES OF THE DEATH** Natural Causes Following a post mortem, the medical cause of death was determined to be: **1a Multi-organ failure / septic shock** **1b Staphylococcus Aureus Septicaemia** **1c Cellulitis** **II Vascular insufficiency due to atherosclerosis**
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. - 1. The evidence of [redacted] suggested that proper skin inspections and skin

	monitoring were not carried out between 14th to 18th March 2021 as, had they had been carried out, they would have been documented and recorded in detailed body maps. 2. The evidence of [redacted] suggests that skin inspections were carried out but were not recorded. It was admitted by [redacted] in evidence that there was a failure to keep proper and adequate records by staff. 3. At inquest I found that, on the balance of probabilities, inspections were carried out but observations were not recorded and records were not kept. 4. It was unclear whether this was a "one-off" incident or whether it reflected a systemic issue. On reflection, the fact that records were not taken or kept over a period of four consecutive days (as opposed to one isolated day), is indicative of a systemic issue that staff are not ensuring that their observations are correctly and adequately recorded. 5. It is clear that a failure to ensure that there is a correctly working system of record taking poses a risk of future deaths occurring, especially in the context of extremely frail and vulnerable adults/residents who in a position of dependency by virtue of their frailty or vulnerability.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 19 October 2021. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Next of Kin I have also sent it to the CQC who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**24 August 2021**

	Signature:  **Adam Hodson** **Assistant Coroner for Birmingham and Solihull**